- 3. For primary sites where both tumor size and extension determine the T category in TNM select the code that best explains how the information in the CS Tumor Size and CS Extension fields were determined.
 - a. If there is a difference between the derived category for the tumor size and the CS extension, select the evaluation code that reflects how the worse or higher category was determined.
 - b. If the patient had no surgery, use code 0, 1, or 9.

Example:

- A. Patient has a chest x-ray showing an isolated 4cm tumor in the right upper lobe. Patient opts for radiation therapy. Code this field as 0. Staging algorithm would identify information as clinical (c).
- B. Colon cancer with colonoscopy and biopsy confirming cancer. Code this field as 1. Staging algorithm would identify information as clinical (c). The biopsy does not meet the criteria for pathologic staging.
 - c. If the patient had surgery followed by other treatment(s) use code 3 or 9.
 - d. If the size or extension of the tumor was greater after presurgical treatment than before treatment, use code 6. This code is likely to be used infrequently and maps to the "y" intercurrent treatment staging basis.
 - e. If the patient had an autopsy, use code 2 if the diagnosis was known or suspected prior to death. Use code 8 if the malignancy was not known or suspected prior to death.
- 4. For sites/histologies where there is no TNM schema, this field must be coded 9, Not Applicable. These sites are also noted in the site specific schemas.

Note: Although TNM staging is not collected by TCR, TNM is incorporated in the CS system; therefore rules must be consistent.

These schemas are:

Other pharynx Other digestive Middle ear

Other sinus

Trachea

Other respiratory

Other adnexa
Other female genital

Other male genital

Other urinary

Brain and Other CNS

Other endocrine Other eye

Melanoma of other Eye

Kaposi sarcoma

Hematopoietic, Reticuloendothelial,

Immunoproliferative and

Meyoloproliferative Neoplasms

Other Ill-defined and Unknown Primary Sites

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